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Review Article

INDONESIAN PRIMARY CARE THROUGH UNIVERSAL HEALTH COVERAGE SYSTEMS: A FEELING IN BONES

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ABSTRACT
Jaminan Kesehatan Nasional or *JKN* realized as the one of problem solving for equity of healthcare in Indonesian setting. At the same point, it has to compatible with all aspects in health financing issues by its newly adopted systems. This review aims to reveal *JKN* health financing policy since it implemented by 2014 in Indonesia. Several bibliographies databases were identified to conduct literature reviews that comprised of international and national/local journals. It founds that *JKN* principles focuses on mutual support, not-for-profit, good governance, and portability aspects. *JKN* enrollment consisted of two types polisholders including incapable polis insurance (*PBI JKN*) that bear by the Indonesian government, and capable polis insurance (none *PBI JKN*). *JKN* have to synergize with recent existing challenges including integration from previous regional health insurance (*Jamkesda*), healthcare facilities, package benefit, financing issue as well as the deficit issue which happened as lower dues that making by *JKN* polisholder than the high claim by the healthcare facilities particularly in hospitals. Although, *JKN* emerges to tackle the inequity of healthcare in all Indonesian regions, the existing settled *Jamkesda* in several regions, particularly regions with high regional income, made *JKN* integration as the setback health financing on its regions. Limited healthcare facilities that cooperated with *BPJS-Kesehatan* also challenged the *JKN* implementation as well as financial lose in affecting by mismatch between medical expenditures with *JKN* claimed as per package. It concludes that the political willing to choose several options including to prevent *JKN* deficit depend on the leader commitment to make *JKN* as not for another journey but it shall be the destination for health financing in Indonesia.

Keywords: health financing, universal health coverage, health insurance, national health insurance, Indonesia

INTRODUCTION

Health care is the most needed care by anyone that wants to healthy living that could not be negotiated. Sometime, it is no matter how much people have to pay for having healthcare, particularly in developing country setting such as Indonesia. Indonesian public health systems are currently providing an ideally social security assurance for health, namely Indonesian universal health coverage (*Jaminan Kesehatan Nasional* or *JKN*). In previous circumstances, Indonesian people tent to achieve standard healthcare by cost (out off pocket), but if they uncapable to afford it, they will resisted by healthcare providers as a formed of violation to both patient and human rights (Widjaja, 2014). In this case, a healthcare facility more likely neolib than where it depended on how much money they

can obtain from patient. Meanwhile, other developing countries have already successfully implemented their newly and reformed health systems almost in detail family medicine including new structure of primary care (Põlluste & Lember, 2016; Tkachenko, 2017). Otherwise, it also varied by fraud or in-appropriate healthcare that included maximum drug or therapy referred while the same outcome but cheaper than out-off pocket were available (Aspinall, 2014).

In this era, *JKN* presents a health system that has enabled the health expenditure that is no longer burdening the patient. The financial bussines of this system runs by an independent management agency for health namely national healthcare security committee (*Badan Penyelenggara Jaminan Sosial Kesehatan* or *BPJS-Kesehatan*) (Mboi, 2015).

METHODS

In this review, the literatures were search in both international and local bibliographic sources i.e. MEDLINE, EMBASE, CINAHL, Cochrane Library, Science Direct, ProQuest, WHO SEARO database, SCOPUS, Wiley Library, SAGE, Taylor & Francis, SpringerLink, Hindawi, and Directory of Open Access Journals (DOAJ). This study also search literature not listed in the above bibliographic resources using Indonesian Portal Indexing (IPI), and it examined the recent literature on the current issue and prospects for the current health insurance of Indonesia with *JKN* as a main outcome for the review discussion resulting from the government policy associated with update circumstance of Indonesian *JKN* in numerous studies.

PRINCIPLE

BPJS-Kesehatan system that underlined systematic step to ensure the *JKN* conservative fund for utilized efficiently (Indonesian Government, 2004). Healthcare provider is paid by prospectively such as capitation, casemix based group (CBG) or in specific budgeting. For example, Indonesian government is commited that there are only two ways to paid it that consisted of capitation and CBG (PerPres RI, 2013). *BPJS-Kesehatan* in health facilities discussed about standard cost of healthcare on both primary and secondary health facilities that determined by the claim of diagnose related system as well as in CBG (Indriani, Kusnanto, Ghufron Mukti, & Kuntoro, 2013). CBG is not only utilizing by uncapable patient but also it uses by capable registrant. Capable registrant is meaning as polishanded of *JKN* who covered their health assurance by themselves. Meanwhile, uncapable registrant that unable to paid their health assurance, so the government has to pay it for them. CBG model applied the claim payment of *JKN* to the healthcare facilities based on healthcare packaging that formed by the group of disease diagnostics (Hadning, Ikawati, & Andayani, 2015; Hasanah, Mahawati, & Ernawati, 2013). CBG tarif was concluded and it issued by 10th International Code for Disease (ICD X). Periodically, this code shall be revised and analyzed for the appropriateness circumstance of healthcare facilities's data and it also reviewed the previous *JKN* implementation in order to produce and fixing the cost method's calculation (Mundiharno & Thabrany, 2012).

JKN principles are comprised of following: (a) Mutual support; as major core of *JKN* principle which is meaning spirit and practice when capable helps noncapable participant, low risk helps high risk, and the healthy supports the sick. These three components are not happened on comercial health insurance, so it shall be realized social equity for all society. (b) Not-for-profit; shall not be beneficiary on either of partial people or board executive, which also called shareholders. Legally, it collected as trust fund and utilised for healthcare payment. (c) Good governance; consisted of openness, caution, accountability, eficiency and efectivity. It included of policies, revenues, expenditures, investments, and any others transactions should be recorded and archieved for surely. External audit board obligated to examine and verified it publicly. Otherwise,

chief of *BPJS-Kesehatan* have published the accountability and audit results publicly on official website. (d) Portability; meant participant to not only produce benefit, but also healthcare that became participant's rights (Mboi, 2015). Portable also expressed mobility that is valid on all healthcare entities and it is following the dynamic of participant's needs. *BPJS-Kesehatan* also cannot impose restriction of assurance in any region or area in any setting of populations.

ENROLLMENT

In the meaning of the participant is any person, including a foreigner who works for a minimum of 6 (six) months in Indonesia, who has paid the dues. While the worker is any person, who works by receiving the salary, wages, or other forms of remuneration. Participants include *JKN* incapable polis insurance (*PBI*) and none *PBI JKN* with details as follows:

Table 1 *JKN* enrollment procedures (Indonesian Government, 2004, 2011)

***JKN* enrollment types**			***JKN* mechanism of registration**
PBI JKN participants consisted of people who categorized as poor and disadvantaged.			Registration requirement, terms of registration will be arranged later in *BPJS-Kesehatan* rules
None *PBI JKN participants* are the rest who not classified as poor and disadvantaged persons consisted of:	Wage-earning workers and members of their families, namely: civil servants, members of the military (*TNI*); members of the police; state officials; non-government employee; government employee; private employees	Registration location for Participant Registration have done at the nearest/local *BPJS-Kesehatan* office	
	Non-beneficiary workers and their family members, namely: a. workers outside the employment relationship or self-employed b. workers who do not include letter a who are not wage earners. c. workers as referred to letters a and b, including foreign citizens countries working in indonesia for a minimum period of 6 (six) months.	Participant registration procedure	1) The government registered *PBI JKN* as a member to *BPJS-Kesehatan*. 2) Employers enrolled their workers or workers enrolled as members to *BPJS-Kesehatan*. 3) Not-workers and other participants are required to self-register their selves and their family as members to *BPJS-Kesehatan*.
	Non-workers and members of their families consist of: investors; employer; pension recipients; veteran; pioneer of independence	Rights and obligations of the Participant	Every participant who has enrolled in *BPJS-Kesehatan* entitled to: a) the identity of the Participant and b) the benefits of health services at the Health Facility which had collaboration with *BPJS-Kesehatan*. Every participant who has registered with *BPJS Kesehatan* have obligatory to: a) pay dues and; b) report membership data to *BPJS-Kesehatan* by showing the identity of the participant when moving domicile/or transferring work.
	The pension recipients consist of: civil servants who have retired with the right to retirement; members of the TNI and members of the	Phasing of membership	JKN participation shall conduct in several stages. The first phase commencing on 1st January 2014, where its membership shall include at least the following: *PBI JKN*; members

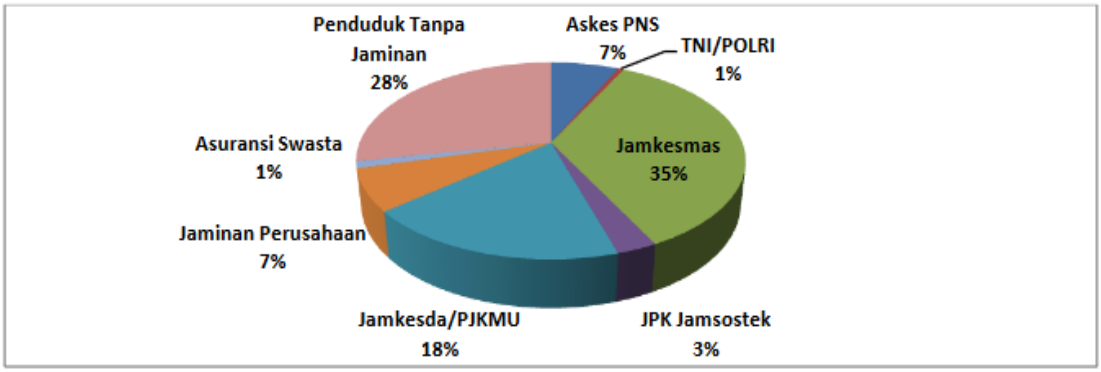
JKN enrollment types	*JKN* mechanism of registration
police who stopped with the right pension.	of the *TNI*/civil servants within the Indonesian Ministry of Defense along with their families; members of police/civil servants within the Indonesian Police along with their families; health insurance participant of *PT Askes* along with their families, and participant of *Jamsostek* along with their families member. Furthermore, the second phase included all residents who have not entered as participants of *BPJS-Kesehatan* for enrolled no later than January 1, 2019.

CHALLENGES

Integration From Previous Regional Health Insurance

JKN program is expected to provide many changes to the health system in Indonesia, such as financing management, health service management, information management, cross-sector coordination, and others. Furthermore, the system is also expected to affect other aspects beyond the health system itself, such as economic aspects; business aspect, employment aspect, and wage aspect; aspects of poverty reduction and social protection; up to aspects of data collection and population registration. Participants of *JKN* as of January 1, 2014, were participants of health insurance programs that are transferred directly to *JKN* program, namely *Jamkesmas* participants, civil servant health insurance (*Askes PNS*), military health insurance (*Askes TNI/POLRI*), and health assurance network for labor (*JPK Jamsostek*). From that moment onwards, *BPJS-Kesehatan* opened registration for every citizen who wanted to register *JKN*, either individual, through the company, or through local government as Local Contribution Receiver (*PBI*). *BPJS-Kesehatan* estimated the number of participants *JKN* as of January 1, 2014, as much as 48.2% of the total population of Indonesia (Widodo, 2014), or as many as 110.4 million people. The President Act of Health Insurance mandates that all Indonesian citizens should be registered as *JKN* participants in achieving Universal Health Coverage (UHC) in 2019 (Supriyantoro & Hendarwan, 2014).

Gambar 1. Peserta Berbagai Skema Jaminan Kesehatan di Indonesia Juni 2013



Sumber: Mukti, Ali Ghufran. Presentasi: Indonesia on Its Path to Universal Health Coverage-Expanding Coverage for Informal Sector. 2013

Previously, all provinces in Indonesia have already a regional health insurance (*Jamkesda*) respectively with there were four provinces that have settled *Jamkesda* financing (Supriyantoro, Hendarwan, & Savithri, 2014). The number of provinces that only guarantee the participants of none *Jamkesmas* poor were 27 provinces (81.81%), while two provinces (6.06%) using uncapable recommendation that issued by incapability-confirmed letter (*SKTM*) (Supriyantoro & Hendarwan, 2014). It indicated that the understanding and ability of each regions in *Jamkesda* management were varied, especially to achieve settled Universal Health Coverage (UHC).

Based on the characteristics and feasibility analysis of *Jamkesda* policy in 6 provinces, there were several points to consider in the formulation of the integration policy formulation as follows: 1) The existing regulations and action plan at the provincial level which would determine the how far the *Jamkesda* integration process works well; 2) The political commitment of regional leaders, which was in general it should be visionary regarding to the preparation of *JKN* implementation after; 3) Field preparedness which was also a key that should wellprepare during the *Jamkesda* integration process into the *JKN*, concerning limited access, availability of health services and *BPJS-Kesehatan* that distributed evenly and the quality of standards, as well as the level of knowledge/awareness of the community; 4) The ability of regions to adjust *Jamkesda* policies compiled with the regional middle development plan (*RPJMD*) performance indicators which was essential in the integration process, as it should synergy in each region respectively; 5) Economic and financial factors, particularly the readiness of local budgets with determination the readiness of regions to integrate; 6) Result basis financing that may bridging the existing system differences and improve performance both concerning to supply and demand from health systems in achieving Universal Health Coverage (Supriyantoro & Hendarwan, 2014; Supriyantoro et al., 2014).

Health Facility

Implementation of the *JKN* led to increased utilization of services in health facilities, especially hospitals (Nugraheni, 2015). Integration into *JKN* Jamkesda participants would also be escalated the number of service utilization (Ambarriani, 2014; Supriyantoro & Hendarwan, 2014). Several problems shown in relating to the limited healthcare facilities that caused people cannot take advantage of these health facilities despite having health insurance. For example, the case of patients who end up having to find another hospital after a very long wait for a treatment room, a patient rejected by the hospital, especially those needing the emergency care such as ICU (Sandhyaduhita et al., 2016). In relating with the rise of *PBI JKN* patient rejection by the hospitals, this issue triggered the moral hazard that harmed the community and the patient to declared theirselves as a general patient so it can be served faster and more secure than if admitted as a *JKN* patient whose responded by slowly and unfriendly from the hospitals.

Package Benefits

Concerning benefit package for *PBI JKN*, Presidential Act No.12 of 2013 has clearly stated details of benefits received by *PBI* (Pemerintah RI, 2013). However, in practice, the benefits package not entirely obtained by patients or due to poor hospital management that affected patients have to spend their money (out-off-pocket) to fulfil the needs of health care (Veruswati & Asyary, 2017b). Also, the benefits package in *JKN* does not adequately fulfil the needs of particular patients, for example, specified drugs according to the national formulary (*Fornas*) (H Thabrany & Abidin, 2017). In *BPJS-Kesehatan* perception, *Fornas* drugs has been fully met the standard needs of the treatment (Indonesian Government, 2011). In fact, several hospitals made patients to out-off-pocket for particular receipt in pharmacies outside the hospital (Veruswati & Asyary, 2017a). Furthermore, *Fornas* itself is a list of drugs that do not include the trading name of medicine and it only written as the active substance of the drug (Pemerintah RI, 2015). Thus, it led the hospitals to made patient that

have to pay for anonymous trading name of the drug as caused by unavailability of the *Fornas* medication. On the implementation of JKN, it should be able to encourage hospitals to improve the management of services including providing the stock of medicines and medical supplies in considering the increased utilization of health facilities.

Besides, the hospitals complained about the difficulty of accessing e-catalog (Dwiaji, Sarnianto, Thabrany, & Syarifudin, 2016; Kusmini, Satibi, & Suryawati, 2016). It carried on as common event as e-catalogs run the mechanism for the tender of medicines and medical consumables needed in government health facilities (Hasbullah Thabrany, Sari, Tilden, Dunlop, & Hajaraeni, 2015). The hospital in collaboration with *BPJS-Kesehatan* should cooperate with pharmacies which appointed by *BPJS-Kesehatan* to provide medication for *JKN* participants. It indicated that the government still needs to educate and provide the explanation for the private sector that cooperates with *BPJS-Kesehatan* and prevent patient's rejection by the hospitals.

Deficit

As a newly-innovate insurance, *JKN* is aimed to afford health equity access for all Indonesian mankind. *JKN* alongside with Health Indonesian Card (Kartu Indonesia Sehat or KIS) have succeeded to covering more than 178 millions (more than 60%) of Indonesian society (BPJS Kesehatan, 2017). Otherwise, *JKN-KIS* allowed increasing Indonesian people to have their health insurance in such a way (Andria & Kusnadi, 2017; Habibie, Hardjosoekarto, & Kasim, 2017). Based on enrolment distribution data of The National Healthcare Security Committee (*Badan Penyelenggaran Jaminan Sosial Kesehatan* or *BPJS-Kesehatan*) on March 2017, participant still enrolled dominantly by Recipient of Contribution Subsidy (Penerima Bantuan Iuran or PBI) with 52% rather than the other policyholders (24% employee, 12% non-employee/entrepreneur, 3% government shareholders, and 9% integration from previous local government health assurance or Jamkesda) (BPJS Kesehatan, 2017).

One of the basic huge problems is emerging as unequally between total revenue that is coming through participant subscription received with total expenditure both for claimed payment (hospital) and capitation (health center) that called mismatch. It should be acknowledge that mismatch is hardly to avoid as caused by subscription structure that set by the government was below from real actuarial accounting. In fact, actuarial accounting has been calculating and set the cut-off point as ideally subscription for *BPJS-Kesehatan* anyway. However, it decided, always, by considering the political and economics policy. The government amended the subscription amount below actuarial accounting ideally. And automatically, the consequences of these policy felt as current situation (Lestari & Djamaludin, 2017).

In 2015, subscription average was IDR 27,000 per person per month, while its claiming expenditure was reached IDR 33,000 per person per month. Thus, deficit happens IDR 6,000 per person per month with 145 millions participants, so it achieved 10.4 trillions deficit (BPJS Kesehatan, 2017). This concludes that *JKN* revenue is still far away from its expenditure. On the other hand, this situation will also influence to quality and pattern of health care. Therefore, the government is essential to improve the fiscal capacity to accommodate health financial needs, including *JKN* financing.

Obviously, the Government Act No. 24 of 2011 about *BPJS-Kesehatan* had been amended the mechanism of *JKN* financing. Unfortunately, its financial regulation have not detailed as expected yet, while it hopes that it can be cover whether with government regulation No. 87 of 2013 about Management of Health Social Assurance Asset or the revised version as government regulation No. 84 of 2015, however, it seems that these latest regulations were only the repetition from the prior act without any particular meaningful in addition.

There are several options to avoid mismatch in future deadlock for further. According to the

Government Act No. 24 of 2011 about *BPJS-Kesehatan*, article 43 set about asset of social assurance fund of *BPJS-Kesehatan* could be origin by: (a) social assurance subscription including subsidy subscription; (b) it produces from social assurance fund development; (c) it produces from asset by social assurance program that comes from national companies (Badan Usaha Milik Negara or BUMN); and (d) other legitimately sources that approves by government act and regulation.

Indeed, the mainly factor is changing the subscription participant at least equivalent to actuarial accounting which is by escalating the current subscription participant. However, it should consider the political issue. Meanwhile, investment program seems tantalizing but it is more difficult to regulate either for the profit (Fossati, 2016), investors requirement, and investment methods in such a way (Trisnantoro, Marthias, & Harbianto, 2014). Otherwise, in effort to interpreting the last option as seeking for other legitimately source is essential to earmarking the best benefit health care (Hasbullah Thabrany & Laborahima, 2016), as well as to reduce the morbidity and mortality, for further.

CONCLUSION

As the singular national health insurance, *JKN* showed by the powerful policy to adopt its scheme in all of the regions at this country. It indicates that the political commitment is the main venue to implement it beyond the rest factors including current challenges such as the *Jamkesda* integration and the deficit. These challenges should be the opportunities in making *JKN* for not only the one of the journeys but the destination of the health insurance in Indonesian.

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Conflict of Interest

The author has no conflict of interest to declare that related to this paper.

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